



QUARTERLY STATEMENT OF ESTIMATED PREMIUM AND ASSOCIATED TAX

State Form 38337 (R/9-2005)
Approved by the State Board of Accounts 1987

Make check payable: **Indiana Department of Insurance**

Send remittance with form to:

**Indiana Department of Insurance
Bank Lockbox
P.O. Box 577
Indianapolis, IN 46206-0577**

INSTRUCTIONS

1. Must be typewritten.
2. Send separate checks and forms for each company, to the above address; no other address is acceptable.
3. Must be received at the instructed address no later than the date due.
4. Quarterly Estimated Tax Payments and forms are to be received by April 15, June 15, Sept. 15 and Dec. 15
5. U.S. Postal Express, U.S. Priority Mail, Certified U.S. Mail and regular U.S. mail are the only methods acceptable.

QUARTERLY STATEMENT OF ESTIMATED PREMIUM AND ASSOCIATED TAX FOR QUARTER ENDING _____, 20____

State of Incorporation		NAIC Number (5 digit)
Name of Insurer		
Contact Address (Street, City, State and Zip Code)		
Contact Person/Title or Position	Contact Phone ()	Contact Person's Email Address
1. Basis for Estimates: (A) Total Indiana Premium and Associated Tax paid for business written during the prior calendar year		\$
2. Estimated Premium Tax installment due, must be at least: (A) One-fourth of the total Indiana Premium and Associated Tax paid for business written during the previous calendar year (1/4 of Line 1A) or (B) One-fourth of 80% of actual premium and associated tax for the current year		\$
3. Composition of Premium Tax Payment: (A) Amount of Payment – Item 2 (A) or (B) above		\$
(B) Less: Prior Year Overpayment (if applicable) Report up to amount of tax due, do not exceed tax liability.		\$
(C) Net Premium Tax Payment (3A less 3B)		\$
(D) Late Payment: Include 1% interest per calendar month, or part thereof Please include interest payment, to avoid incurring additional interest.		\$
(4) Total Payment Remitted (sum of: 3C and 3D) (If amount is less than zero; enter zero)		\$
I certify that the above estimated quarterly premium tax payment has been calculated in accordance with the provisions of Indiana Statutes, Section 27-1-18-2, 27-1-20-12, and to the best of my knowledge and belief this is a true, correct and complete statement of premium and associated tax due.		
Name and Title of Person preparing statement:		
Signature of Preparer:		
Name and Title of Authorized Officer:		
Signature of Authorized Officer:		
Date Signed (MM,DD,YY):		

**Notary
Seal**

Subscribed and sworn to before me this _____ day

of _____,

County of _____

My Commission Expires _____

Signature of Notary Public

FOR INSURANCE DEPARTMENT USE ONLY